Iowa Medicaid Enterprise strives to process submitted Medicaid Meaningful Use EHR Incentive program attestations in a timely manner. However, sometimes the information submitted within the attestation is incomplete, incorrect, or incomprehensible.

To assist in expediting the attestation review, keep the following tips in mind prior to submitting your attestation for review:

Patient Volume vs. Meaningful Use

Patient Volume is just *one* piece of the meaningful use *eligibility requirements*, proving the provider has enough *Medicaid* patient encounters to qualify for the *Medicaid* EHR incentive program. This calculation always comes from the previous year to the incentive year. Example: 2016 incentive year, patient volume comes from any continuous 90 day period in 2015. This way all claims would have adjudicated and Medicaid is able to validate the patient volume in the attestation.

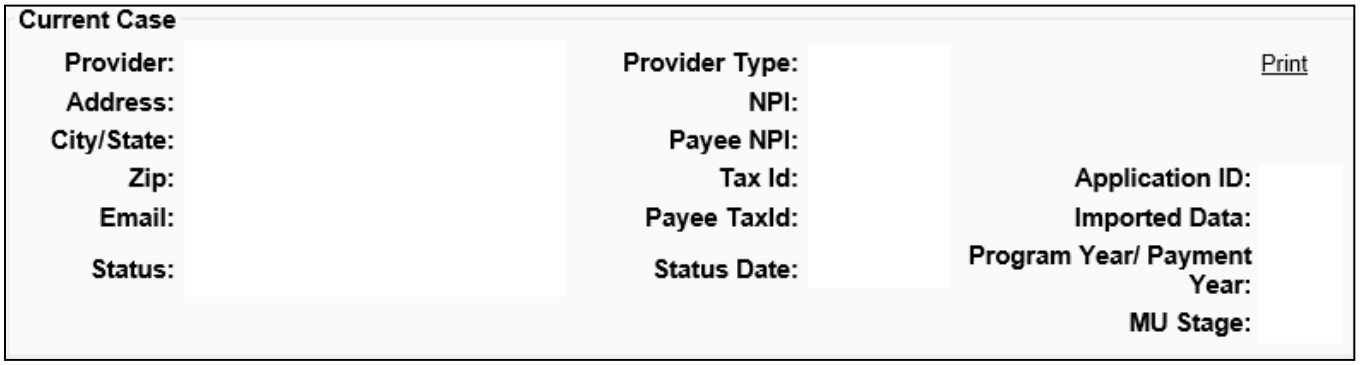
Meaningful Use data shows that the provider is meaningfully using the EHR system and meeting the objectives and measures of meaningful use. The Meaningful Use reporting period is always within the incentive year. Example: Incentive year 2016 Meaningful Use data comes from 2016. Depending on the number of years of participation within the Meaningful Use EHR incentive program, a provider may report on a continuous 90 day period or a full calendar year.

Current Case and Provider Questions Screen

Check over the provider questions and current case information with the following in mind:

Current Case

This information shares over to Iowa Medicaid's EHR Incentive attestation site (PIPP) from the CMS Registration and Attestation site https://ehrincentives.cms.gov/hitech/login.action. Ensure all data is correctly listed. If not, you must return to CMS Registration and Attestation site and make corrections. The information will share over to PIPP overnight.



Provider Questions Screen

Are you currently enrolled to **bill** as an Iowa Medicaid Provider?
If you are registered with Iowa Medicaid as a referring/prescribing provider mark this question as NO
If applicable, provide the supervising physician's NPI
Ensure the patient volume documentation clearly states the provider name and what NPI(s) Medicaid should look at to validate the Medicaid encounters.

What is the NPI of the organization for which you bill?
Verify your answer on the provider questions screen. Does this match the Payee NPI of your current case information? Should it?

Professional License

Go to the "Provider Questions" page and confirm whether the license number you entered is correct, and is the same license number on file with Iowa Medicaid.

If needed, you can contact Iowa Medicaid provider enrollment at 1-800-338-7909 (option 2) or in Des Moines 515-256-4609 (option 2) or by email at IMEProviderEnrollment@dhs.state.ia.us

Patient Volume Questions
Check the patient volume calculation, selected 90-day reporting period, and your supporting documentation with the following in mind:

Patient Volume comes from the previous year to the incentive year. Example: Attesting for the 201**6** incentive year, your patient volume would come from any continuous 90-day period in 201**5**.

Definition of a Medicaid encounter as it pertains to the patient volume calculation:
Services rendered on any one day to an individual; where the individual was enrolled and eligible for Medicaid services.

Note: Individuals meeting the definition of *needy individuals,* or those receiving assistance from CHIP (hawk-i) do NOT count toward the Medicaid patient volume, except for EPs meeting the definition of *practicing predominantly* in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).

The following Medicaid encounter types can be used to calculate patient volume:
Medicaid as primary or secondary insurance, zero-paid, unbilled, Magellan, Medicare crossover, out-of-state, MediPass

If you are including zero paid, Medicare crossover, unbilled, denied, or global encounters in your numerator; ensure your patient volume documentation **includes the Medicaid Member ID, date of service and clearly indicates whether the service was zero paid, unbilled, denied, global, or Medicare crossover.** Provide adequate documentation which separates and sums the types of Medicaid encounter data.

Zero Paid

- A claim was submitted to Medicaid, and Medicaid paid nothing; zero
- A remit was issued showing zero dollars were paid by Medicaid
- The documentation should indicate ZERO PAID and include the Medicaid Member ID and Date of Service
- The documentation should indicate the total sum of zero paid which are included in the numerator

Unbilled

- A claim was NEVER submitted by the provider to Medicaid to receive payment. Not having been billed or charged for: unbilled medical charges
- There will not be a remit for this, as the service provided was **never billed** to Medicaid
- The documentation should indicate UNBILLED and include the Medicaid Member ID and Date of Service
- The documentation should indicate the total sum of unbilled which are included in the numerator

Denied Claims

- A provider saw a Medicaid member on a date of service and submitted a claim for the services, but Medicaid DENIED the claim
- The documentation should indicate DENIED and the Medicaid Member ID and Date of Service
- The documentation should indicate the total sum of denied which are included in the numerator

Global

- A provider saw a Medicaid member on more than one occasion, but only received one singular payment, or global payment, for the services rendered.
- Global encounters are most common for pregnancy and dental
- The actual global payment may or may not have occurred within the 90 day selected patient volume reporting period.

- The documentation should indicate GLOBAL and include the Medicaid Member ID and Date of Service
- The documentation should indicate the total sum of global encounters which are included in the numerator

Medicare Crossover

- When Medicare crosses the claim to Medicaid it drops the rendering (individual provider) provider's NPI
- If attesting as an individual provider or a group definition by physical location, then additional documentation is needed
- The documentation should indicate MEDICARE CROSSOVER and include the Medicaid Member ID and Date of Service
- The documentation should indicate the total sum of Medicare Crossovers which are included in the numerator

Review the information on your attestation, provide any clarity, and make any revisions as appropriate.

Group Patient Volume

Check the patient volume calculation, selected 90-day reporting period, and your supporting documentation with the following in mind:

Group Attestation

Clinics or group practices will be permitted to calculate patient volume at the group practice/clinic level, but only in accordance with all of the following limitations:
(1) The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP.
(2) There is an auditable data source to support the clinic's or group practice's patient volume determination.
(3) All EPs in the group practice or clinic must use the same methodology for the payment year.
(4) The clinic or group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way.
(5) If an EP works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the EP's outside encounters.

Review your patient volume calculation and ensure you have been *all inclusive* for your patient encounters.

Iowa Medicaid Group Definitions:

Group NPI: Calculate all encounters from EVERY provider associated with this NPI and then determine ALL of the Medicaid qualifying encounters for the same group of providers.

Physical Location: Calculate all encounters from EVERY provider that practices at this location and then determine ALL of the Medicaid qualifying encounters for the same group of providers.

Tax ID: Calculate all encounters from EVERY provider associated with this Tax ID, and then determine all of the Medicaid qualifying encounters from the same group of providers.

Note: This method will often encompass several different billing NPI's across different physical locations. To expedite the validation of your patient volume; indicate at the top of the documentation the billing NPI's associated with your attestation.

Review the information on your attestation, provide any clarity, and make any revisions as appropriate.

Insufficient EHR Documentation

To qualify for the EHR incentive program, you must *show* that you have the current, required version of certified electronic health record technology (CEHRT).

NOTE: A screenshot from the CHPL website (http://oncchpl.force.com/ehrcert) is **NOT** sufficient documentation.

We must be able to determine that you have purchased, leased or otherwise obtained access to a **certified EHR system**, or have implemented and begun using or upgraded your EHR system to a **certified EHR system**. We must be able to determine the full, exact name and version number, of your certified EHR product. The "EHR Questions" page lists the types of acceptable proof as follows:

- A page of the contract or lease showing the provider, vendor, and name of the certified EHR technology and the dated signature page.
- If your current contract/lease agreement requires the vendor to provide you with appropriate updates/upgrades including certified EHR technology, a signed and dated copy of amendment/attachment showing the installation of certified EHR technology.
- A copy of your invoice or purchase order identifying the vendor and certified EHR technology being acquired and proof of payment.

Ensure your EHR documentation meets the aforementioned requirements.

Meaningful Use Questions

Public Health and Specialized Data Registry Reporting: If you attested YES to meeting the measure(s), then you must upload supporting documentation for the level of active engagement for which you attested.

Review your meaningful use documentation, the data entered on the meaningful use questions screen, ensure the data matches and was correctly entered, and all documentation supporting the attestation has been uploaded.

Meaningful Use Clinical Quality Measures

Review your CQM documentation and the data entered into the Iowa Medicaid EHR attestation site CQM screen to ensure it matches and is correctly entered.